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**Authorization for Release of Medical  
and Dental Records  
to the Kentucky Board of Dentistry**

I, \_\_\_\_\_ the undersigned, hereby  
**Print full name**

authorizes the full release of any and all medical and dental records,  
billing information, and medical and dental reports from the dentist,  
physician, or other medical personnel, or any licensed health care facility  
regarding the medical and dental history, diagnosis, and treatment  
relevant to my initiating complaint, filed with the Board against

\_\_\_\_\_ to the Executive Director of the Kentucky  
**Name of dentist or dental hygienist**

Board of Dentistry, or any authorized agent or investigator of the Board.

The Board's address is: 10101 Linn Station Road, Suite 540, Louisville,  
Kentucky 40223. Copies of such documents may be mailed to the  
Executive Director at this address or hand-delivered to any authorized  
agent or investigator or the Board.

A photocopy of this authorization shall be deemed as effective as an  
original. This authorization shall be effective for one year from the date  
of signing.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of patient or legal guardian of patient**